

Magnitude and patterns of child sexual abuse: A retrospective cross-sectional study among male pediatric patients at Tikur Anbessa Specialized Hospital, Ethiopia

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Abstract

Background: Sexual abuse of boys is a neglected problem in many developing countries, including Ethiopia. As a result, its prevalence and the circumstances under which it often occurs tend to remain unnoticed. Child sexual abuse is frequently reported to emergency departments at hospitals. However, the symptoms can be subtle and masked by vague histories and non-specific physical examinations. The objective of this study was to determine the prevalence and describe the patterns of sexual abuse of male pediatric patients at Tikur Anbessa Specialized Hospital in Addis Ababa, Ethiopia.

Methods: A retrospective cross-sectional study was carried out to describe causes of male pediatric sexual abuse presented to the Pediatric Emergency Unit at Tikur Anbessa Specialized Hospital between the years 2011 - 2015. The number of male children who visited the Pediatric Emergency Unit during the study period was 38,410. Out of these, 327 were suspected to have fallen victim to sexual abuse. A structured questionnaire was used to collect data from the male pediatric patients who visited the Pediatric Emergency Unit with the suspicion of sexual abuse (327).

Results: The prevalence of sexual abuse among male patients presented to the Pediatric Emergency Unit was 0.85%. Twenty-three percent of the victims were between the ages of 1 – 5 years old. The mean age of the abused children was 6.7 years (SD 2.8). The majority of the victims (67.3%) reported the abuse to their mothers. About thirty-six percent (35.8%) of the reports were made within one week of the incident. All the victims were tested for HIV on the first presentation of the incident to the emergency unit. Of those who were tested for HIV, 95.7% were negative. The majority of the perpetrators of the reported sexual abuse were from outside the home of the victims. Neighbors accounted for 55.5% of these perpetrators.

Conclusions: This study provides data for policymakers and other stakeholders to improve the well-being and safety of children. Given that the majority of incidents of male child sexual abuse occur by people children themselves know from outside their homes, strategies that involve the community and that protect children against the threat need to be designed. People to be involved may include parents, health professionals and pertinent personnel from the Ministry of Health. Others such as caregivers, schools, police department, Youth and Women's Affairs, and child advocacy organizations should be called up on to work together and design mechanisms of checking the expansion of this public health challenge. [*Ethiop. J. Health Dev.* 2017;31(4):221-227]

Keywords: Male sexual abuse; Pediatric Emergency Unit; Ethiopia; Community response

Introduction

The American Academy of Pediatrics defines child sexual abuse as "...the engaging of a child in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared and cannot give informed consent, and/or that violates the social and legal taboos of society (1)." The essential components of the definition of sexual abuse involve the child's developmental immaturity and inability to give consent, and the perpetrator's disloyalty to the child's trust. The perpetrator has authority and power over the child due to his or her age or position, and is thus able, either directly or indirectly, to force the child into sexual compliance. In intra-familial sexual abuse, the involvement of the child in sexual activities violates the social taboos of family roles (2).

Sexual abuse is a serious disobedience of child rights that requires a community-wide response, including health professionals. The question of child sexual abuse has been avoided in most parts of the world. This is because accurate diagnosis is difficult without physical examination. In addition, the discussion itself

is emotionally difficult as it involves families, neighbors and wider social institutions (3).

There are multiple reasons why health professionals fail to recognize child sexual abuse. Social and cultural taboos around the thought of adults sexually exploiting children is something not easy to accept. In addition, the skill needed to accurately diagnose child sexual abuse is limited. There are also personal and social anxieties surrounding discussions of sexual topics. There is collective and personal denial in the traditional societies that sexual abuse of children occurs at all. The relative lack of knowledge about whether or not children fall victim to sexual abuse is yet another cause for the avoidance of the topic (4).

It is generally believed that child sexual abuse is underreported. There are many reasons for this underreporting. One reason could be the delayed disclosure of the incident. The child's inability to disclose the incident mainly due to developmental level is another reason for the incident to be underreported.

There are also cases in which the child may not recognize the abusive act is wrong (5).

The longitudinal progression of child sexual abuse may shed light on why a child's disclosure may occur so long after the abuse. Knowledge of why the disclosure itself may be problematic may be instructive of why medical and other professionals should be trained to identify potential symptoms to help ensure early detection. Sexual abuse has different stages: engagement, sexual interaction, secrecy, disclosure, and suppression.

In the first stage of this progression, the perpetrator tries to approach the victim in a friendly manner and spends time with the child, often buying presents or giving some treat to the child. The perpetrator then engages the child in age-inappropriate sexual contact such as showing the child sexual images. This may go forward to genital contact in some cases (6). The perpetrator wants to keep the contact secret by warning the child or giving special care and obtain continued access to the child. This secrecy may be the result of obvious or indirect terrorization.

The child's disclosure may eventually occur by accident. Or the child may also intentionally tell someone about the abuse. However, once one child has disclosed, many children may retract or hold back the disclosure due to demands from others or due to penalty of the initial disclosure (7). Parents, under certain circumstances, may not themselves disclose the abuse. The circumstance in which the victim's parents are economically dependent on the perpetrator could be mentioned as an example in which sexual abuse of children may not be reported by parents.

In Ethiopia, talking about sexual abuse in general is like talking about social taboo. Sex in general is not a topic to be raised for discussion in public. Worse is talking about topics that pertain to male sexual abuse. The issue of child sexual abuse is a taboo in the country although there are more visible socioeconomic traumas for people to talk about in public.

Related studies in the local context are limited both in number and scope. However, one recent study among high schools in Addis Ababa, Ethiopia, reported that the prevalence of rape and sexual harassment among boys aged 18-20 years was 4.3%, and 68.2%, respectively (8). Partly, the initiation for the present study arose from the recognition that very little has been researched in the area in the local context. The objective of this study was therefore to determine the magnitude and describe the patterns of male sexual abuse among male pediatric patients at Tikur Anbessa Specialized Hospital (TASH) in Addis Ababa, Ethiopia.

Operational Definitions

Sexual abuse: The infliction of sexual contact upon a person by forcible compulsion; the engaging in sexual contact with a person who is below a specified age or who is incapable of giving consent because of age or mental or physical incapacity.

Sexual harassment: Uninvited and unwelcome verbal or physical behavior of a sexual nature especially by a person in authority toward a subordinate (such as an employee or student)

Rape: The penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.

Male sexual abuse: Male child who has got non-consensual act of sexual per rectum with penetration or without penetration of the rectum associated with a misuse of power and physical force.

Methods

Study Setting: The study was conducted in the Pediatric Emergency Unit within the Department of Pediatrics and Child Health at Addis Ababa University, Addis Ababa, Ethiopia. The Pediatric Emergency Unit is one of the largest units in the hospital, with 40 to 50 patients seen daily. Patients of all categories of diseases are seen in the emergency unit. Some of the patients are admitted to specialty wards for further treatment. Sexually abused children receive services in the pediatric emergency unit. Averages of 2 sexually abused boys are seen on a weekly basis (Pediatrics Emergency log book).

Retrospective hospital records of 327 male children who were suspected of sexual abuse were obtained from the hospital's Pediatrics Emergency Unit and reviewed.

The medical records considered were records of male children who were presented to Pediatrics Emergency Unit from January 2011 to December 2015. Medical charts of suspected victims at TASH Pediatrics Emergency Unit were kept locked in a separate cabinet to maintain patient confidentiality. TASH Pediatrics Emergency Unit provides service only for male sexually abused children. Female sexually abused children get services in Gandhi Memorial Hospital.

Data for the study were collected using structured questionnaires. Data collectors were recruited and given proper training on the overall data collection procedures. Among others, contents of the training included information on the rationale behind the survey, suggestions on how to ask questions and record responses, best practices for ensuring respondents' confidentiality, and strategies of helping the child feel safe during the survey.

During the data collection process, the collected data were daily checked by the principal investigator for completeness, eligibility, and appropriateness. Patients' records with incomplete information were excluded from the study. Twenty records were found to be incomplete and therefore excluded from the study.

Data were entered into the Statistical Package for Social Sciences (SPSS) software version 21 for analysis. Human subject's ethical approval sheet used during the study was obtained from the Office of Research and Publications, Addis Ababa University. The survey forms did not include personal identifiers in order to protect confidentiality of patients. Prior to accessing the medical records of the study participants,

permission was obtained from the pertinent department.

Results

A total of 64,740 children attended pediatrics emergency unit during the study period. Of these children, 38,410 were male and 26330 were female. Three hundred and twenty-seven of the total 38,410 male children were suspected of facing sexual abuse. There was a variation among years in the number of male children who were screened for signs of sexual abuse. The highest incidence (40.7%) of sexual abuse was seen in 2014 (Table1).

Table 1: Male Pediatric Patients Suspected of Sexual Abuse

Year	Number of abused children	Total number of male patients seen in ER	Percent (%)
2011	22	8856	0.24
2012	46	7635	0.6
2013	52	6790	0.76
2014	133	6365	2.1
2015	74	8764	0.84
Total	327	38,410	0.85

Source: TASH Pediatric Emergency Unit (2011 – 2015)

Participants' age distribution in this study ranged from 1 to 13 years. The mean age of study participants was 6.7 years (SD+2.8 years) (Figure1).

The highest number of reported sexual abuse cases (i.e., 68.2%) occurred in the age range of 7 to 13 years

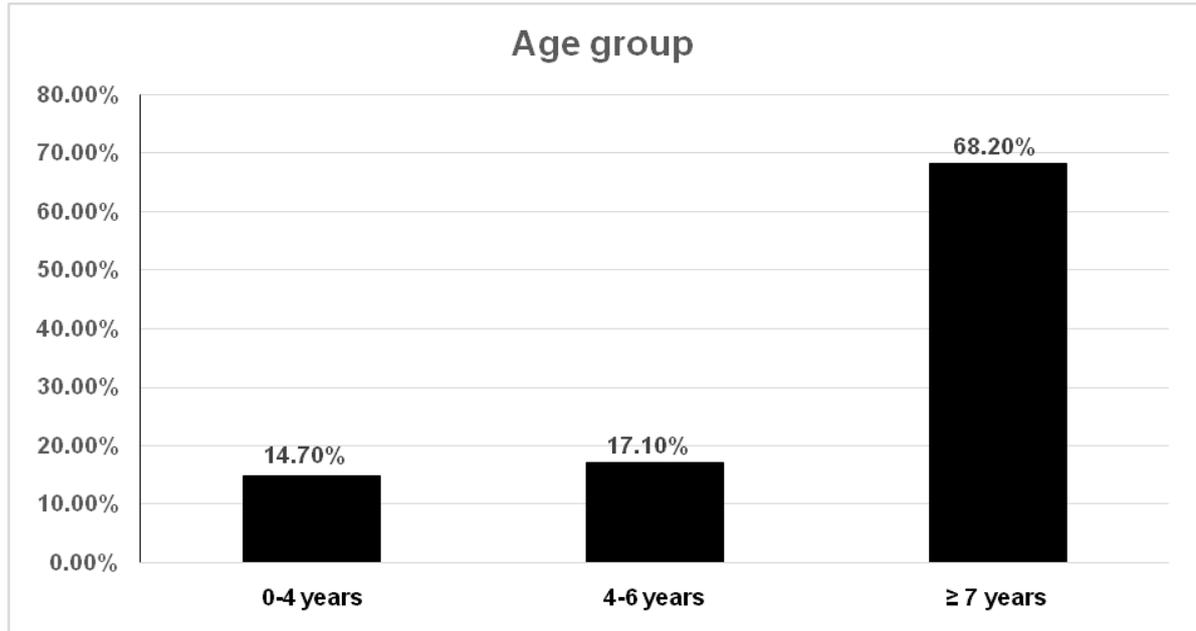


Figure 1: Table 2: Male Pediatric Patients Suspected of Sexual Abuse

Source: TASH Pediatric Emergency Unit (2011-2015)

It can be understood from Table 2 that the association of victim's place of living to presentation after abuse has a statistically significant association (Chi-square 26.87; P-value 0.001). The victim's place of living and the victim's disclosure of the incidence have also a statistically significant association (Chi-square 175.9; p- value 0.000).

Majority of the study participants reported that sexual abuse was committed by someone they knew. Slightly over half (54.1%) reported neighbors as perpetrators of this crime (Figure 2). About a quarter of the respondents reported strangers as perpetrators.

The participants of this study were male sexually abused children from Addis Ababa and its suburbs. A few were also reported to be from the Southern Nations, Nationalities, and Peoples' Region (Table 3). The highest percentage of the reported victims were from Gulele sub-city (12.5%) Addis Ababa. Kolfe-

Keraneyo and Ledeta sub-cities (both from Addis Ababa) had the second highest percentage of incidence of male child sexual abuse. The percentages of the reported abuses were 11.3% from each of the two sub-cities.

Table 2: **Attributes of Sexual Abuse Cases**

Variables	living arrangement			Total	Chi-square (P-value)	
	street boy	living with relatives	living with parents			
Presentation after abuse					26.87 (0.001*)	
In hours	Count	11	1	83		95
	% within presentation after abuse	11.6%	1.1%	87.4%		100.0%
In days	Count	5	5	107		117
	% within presentation after abuse	4.3%	4.3%	91.5%		100.0%
In weeks	Count	2	2	59		63
	% within presentation after abuse	3.2%	3.2%	93.7%		100.0%
In months	Count	1	0	44		45
	% within presentation after abuse	2.2%	0.0%	97.8%		100.0%
In years	Count	0	2	5		7
	% within presentation after abuse	0.0%	28.6%	71.4%		100.0%
Frequency of abuse						2.92 (0.232)
Once	Count	14	6	240	260	
	% within frequency of abuse	5.4%	2.3%	92.3%	100.0%	
2	Count	5	4	58	67	
	% within frequency of abuse	7.5%	6.0%	86.5%	100.0%	
3	Count	0	0	4	4	
	% within frequency of abuse	0.0%	0.0%	100.0%	100.0%	
4	Count	0	0	2	2	
	% within frequency abuse	0.0%	0.0%	100.0%	100.0%	
The victim disclosed					75.9(0.000*)	
Mother	Count	5	2	213		220
	% within the victim disclosed to	2.3%	0.9%	96.8%		100.0%
Father	Count	3	6	70		79
	% within the victim disclosed to	3.8%	7.6%	88.6%		100.0%
Relative	Count	1	1	14		16
	% within the victim disclosed to	6.2%	6.2%	87.5%		100.0%
Caregiver	Count	0	0	1		1
	% within the victim disclosed to	0.0%	0.0%	100.0%		100.0%
Friend	Count	2	1	0		3
	% within the victim disclosed to	66.7%	33.3%	0.0%		100.0%
Neighbor	Count	4	0	0		4
	% within the victim disclosed to	100.0%	0.0%	0.0%		100.0%
Policy	Count	4	0	0		4
	% within the victim disclosed to	100.0%	0.0%	0.0%		100.0%

Source: TASH Pediatric Emergency Unit (2011-2015).

*Statistically significant association with p-value < 0.005

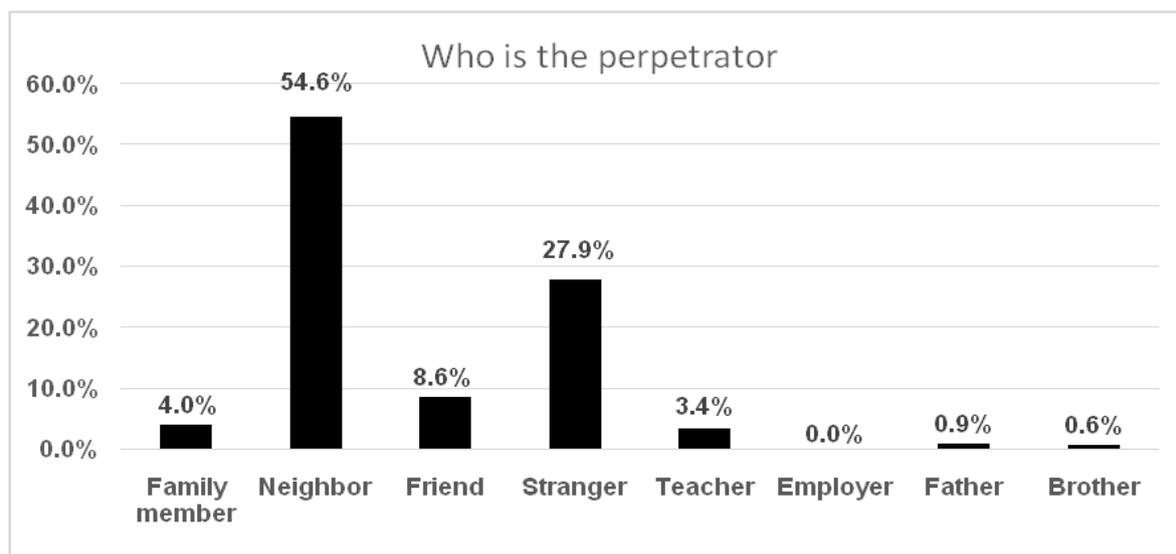


Figure 2: Relationship of Perpetrator to Victim, Source: TASH Pediatric Emergency Unit (2011-2015)

Table 3: Location of the Study Participants (Addis Ababa)

Address	Number	Percentage
Addis Ketema	23	7.0
Nifas silk lafto	36	11.0
Kirkos	15	4.6
Arada	30	9.1
Akaki	32	9.8
Kolfekeranyo	37	11.3
Bole	25	7.6
Ledeta	37	11.3
Gulele	41	12.5
Yeka	31	9.5
Street residents	5	1.5
Outside of Addis Ababa		
Southern South Nationality	2	0.6
Region 4	12	3.7
Total	327	100

Source: TASH Pediatric Emergency Unit (2011-2015)

Up on arrival at TASH, all victims received screening for HIV, Hepatitis B, Syphilis and sperm test at baseline. The test was scheduled to be repeated every 3rd month after their first hospital attendance. Three months after their first reporting of the incidence, however, 93% of the study participants disappeared.

This made following up their test results for HIV and other sexually transmitted diseases impossible. Of those who received a follow-up testing every 3rd month, one victim was found to be HIV positive and another was found to be VDRL positive (Table 4).

Table 4: Summary of Laboratory Tests

Result	HIV		Hepatitis B		VDRL		Sperm test at presentation
	Base line	After 3 months	Base line	After 3 months	Base line	After 3 months	
Positive	2(0.6)	3(0.9%)	4(1.2%)	4 (1.2%)	0	1(.3%)	1(0.3)
Negative	315(96.3%)	22(6.7%)	313(95.4%)	25(7.6%)	317(96.9%)	25(7.6%)	27(8.2%)
Not done	10(3%)	302(92.4%)	10(3%)	298(91.2%)	10(3%)	301(92%)	299(91.2%)
Total	327(100%)						

Source: TASH Pediatric Emergency Unit (2011)

Results of physical examinations of the study participants showed that 75% to 98.8% had no any physical symptom of injury or illness following the

abuse. Results obtained from 1.2 % to 24.4% victims revealed symptoms of pain during defecation, lacerations, or scars (Table 5).

Table 5: Results of Pediatric Patients Physical Examinations

	Pain during defecation	Laceration	Scar
Yes	80 (24.4%)	13 (4%)	4 (1.2%)
No	247 (75.3%)	314 (96%)	323 (89.8%)
Total	327 (100%)	327 (100%)	327 (100%)

Source: TASH Pediatric Emergency Unit (2011-2015)

Discussion

Most estimates of the prevalence of sexual abuse in Ethiopia and other countries are derived from hospital-reported cases. The present study is an extension of a similar practice. This means that the findings of this study are reports of evidence of magnitude and patterns of pediatric male sexual abuse. To conduct the study, first, medical charts of children who attended TASH Pediatric Emergency Unit during January 2011-December 2015 were accessed and consulted. Then, identification of male children who attended the hospital in the years specified earlier was made. Accordingly, from among the 38,410 male children who visited the hospital in the years reported, cases of 327 children who were suspected of sexual abuse were identified and considered in the study.

Data on male sexual abuse in Addis Ababa and its surrounding for different age groups outside of the pediatric years was unavailable. The study was therefore confined in scope to very limited cases obtained from the Referral Hospital located in Addis Ababa. As stated earlier, the main objective of this study was to determine the magnitude and describe the patterns of sexual abuse of male pediatric patients at Tikur Anbessa Specialized Hospital in Addis Ababa, Ethiopia. The subsidiary purpose of the study was to provide preliminary evidence to medical professionals, the scientific community, and policy makers. This may initiate the need for preventative actions.

The magnitude of reported male sexual abuse in this study was lower than the reports released in other studies. For instance, Rahel (2013) studied the prevalence of sexual abuse among high school male students in Addis Ababa. It was reported that 4.3% of the participants considered in Rahel's study were victims of sexual abuse (8).

Tadele, (2009) on his part, studied street children in Markato area and reported that 28.6% of the participants were victims of sexual abuse. It should be pointed out here that the site covered in Tadele's study was a large business and market area in Addis Ababa. The participants in study were also homeless street boys. An explanation for the reported fairly large victim size in the study may get an explanation in the immediate context of the study (9).

Similarly, Jibril studied Child Sexual Abuse Epidemic in Addis Ababa and reported that 23% of the participants of the study were victims of the abuse (10). The age distribution of the victims in the present study ranged from 1 to 13 years. This coincides with a study conducted in India and South Africa (11, 12).

A large number of children were victimized by someone they closely knew. Accordingly, 54.1% were victimized by neighbors. This finding coincides with the finding reported in Indian and in Jibril's studies (11,12, 13,14). In the present study, the highest number of abuses occurred in 2014 (40.7%). This shows an increment in the trend compared to the incidence reported in the earlier year.

With respect to the time of the victim's presentation to hospital after abuse, the highest percentage of the victims in this study reached hospital 72 hours after the abuse. This means that, unlike the cases reported in many other studies, there was a delay in the presentation of victims to hospital after the abuse. The reason given for the delay was that the abuse was kept secret. The perpetrators did this either by warning the victims or giving them special treats (14).

The current study was a hospital-based study in which the victims were presented to hospital perhaps by one of their parents. Close to 90% of the victims in the study were reported to be living with their parents although this could not fully protect them from sexual abuse. Some participants in Rahel's study were reported to be living with their parents while other participants were said to be living on their own. This means that differences in the number of victims of sexual abuse may partly find an explanation in the living conditions of the study participants (8).

The distribution of male sexual abuse in Addis Ababa sub-cities was variable. About 12.5% of the victims were from Gulele sub-city. This is a much bigger percentage compared to those observed in the other sites covered in the study. For example, Akakai, Arada and Yeka sub-cities, combined, accounted for 6% of the victims in the study. The lowest rate of sexual abuse (i.e., 4.6%) was reported to be from Kirkos sub-city.

In the earlier study carried out in Lideta and its surrounding, 15% of the study participants were reported to be victims of sexual abuse. The fact that Lideta is a bigger business center and a more densely populated area than most of the study areas considered in the present study may be taken as an explanation for the high incidence of the abuse recorded in the Lideta-based study.

One of the limitations of the present study was that it was hospital-based and only victims who were presented to the hospital were included. This might affect the representativeness of the male children who participated in the study.

In conclusion, the study indicated that male children sexual abuse is an emerging problem in urban and semi-urban communities in Ethiopia. The future of all children in the country, if such misbehavior is allowed to continue, is at risk. This carries with it the implication that children generally need closer supervisions from parents and care givers. A broad-based study is needed to give us a more in-depth insight into this emerging problem. At the same time, it is also important to think about policy issues, preventive measures and therapeutic interventions that can curb a further expansion of such a malicious act.

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